

STATE OF MAINE

**BOARD OF HEARING AID DEALERS AND
FITTERS**

APPLICATION FOR LICENSURE

- Trainee Permit



Department of Professional and Financial Regulation
Office of Licensing and Registration
35 State House Station
Augusta, ME 04333-0035

Office Telephone: (207) 624-8626
Office Facsimile: (207) 624-8637
TTY/HEARING IMPAIRED (888) 577-6690
Email: jennifer.l.mooney@maine.gov

Application Guide for Trainee Permit

Please read all the information carefully. If you have any questions, you can contact the Board of Hearing Aid Dealers and Fitters office at (207) 624-8626 or email jennifer.l.mooney@maine.gov

TRAINEE PERMIT APPLICATION - A trainee permit is required before applying for full licensure as a Hearing Aid Dealer and Fitter unless the applicant is either a Maine licensed audiologist or qualifies for licensure by reciprocity. The following must be submitted with a trainee permit application:

- ☐ A completed application with a recent photograph attached;
- ☐ Fees: All Checks/Money Orders should be made payable to the "Treasurer, State of Maine". If paying using a credit card please use the Credit Card form at the end of the application. All Fees can be in one payment;
 - **\$100.00** Trainee Permit Fee
 - **\$50.00** Application Fee
 - **\$15.00** Criminal History Check Fee
 - Examination fees (See Examination Instructions)
- ☐ Proof of age. The Board will accept a copy of the applicant's birth certificate, a copy of state driver's license, or other state identification card providing the applicant's date of birth and bearing a photograph;
- ☐ Documentation of an education equivalent of a 4-year course in an accredited high school or official transcript from a postsecondary educational institution;
- ☐ Two (2) written business reference letters indicating the applicant's business attitude and ethics. Most recent employers are preferred; and
- ☐ Two (2) written character references not related to the applicant.

EXAMINATION INSTRUCTIONS:

A. Examination Dates:

The Board of Hearing Aid Dealers and Fitters Written and Practical examinations are held in May and October yearly at the Department of Professional and Financial Regulation, Gardiner Annex, 122 Northern Avenue, Gardiner, Maine. Your application for trainee permit also serves as a request for examination. **You will be scheduled for the next available examination and a separate notice will be mailed to you indicating the date, time, and specific location of the examination.**

B. Written Examination:

The written examination is based upon information in the Distance Learning for Professionals in Hearing Health Sciences, published by the National Institute for Hearing Instruments Studies, Education Division of International Institute for Hearing Instrument Studies. Enclosed you will find a brochure to order this Training Manual.

In addition, students must read the material that is indicated for each lesson in the required textbooks.

C. Practical Examination

The practical examination is based upon the information contained in the NIHIS Uniform Practical Examination Study Guide. See enclosed training manual.

D. Fees

Make fees payable to NIHIS for:	ILE	\$ 95.00
	Practical Exam	\$ 50.00
	Both exams	\$130.00

E. Results

All candidates are notified in writing, approximately 4-8 weeks after examination administration, as to their oral and/or written examination results.



JOHN ELIAS BALDACCI
GOVERNOR

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AND FINANCIAL REGULATION
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Office Use Only		
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Cash #		
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4100	1450	\$100 TR2
4100	1446	\$50
4100	2619	\$15

ANNE L. HEAD
DIRECTOR

APPLICATION FOR LICENSURE

Notice regarding Social Security Number Disclosure

The following statement is made pursuant to the Privacy Act of 1974 section 7 (B). Disclosure of your social security number is mandatory. Solicitation of your social security number is solely for tax administration purposes pursuant to 36 MRSA section 175 as authorized by the Tax Reform Act of 1976 (42 USC section-405 (C) (2) (1)). Your social security number will be disclosed to the State Tax Assessor or an authorized agent for use in determining filing obligations and tax liability pursuant to Title 36 of the Maine Revised Statutes. No further use will be made of your social security number and it shall be treated as confidential tax information pursuant to 36 MRSA section 191.

Notice regarding Public Information

This application is a public record for purposes of Maine's Freedom of Access Law, 1 MRSA §401, et seq. Public records must be made available to any person upon request. Information that you supply as part of this application (except your Social Security number) is public information. Other licensing records to which this information may later be transferred are also considered public records. Where permitted by law, your name, license number, mailing address and other information listed on this application may be posted on the State's website.

TO BE COMPLETED BY THE APPLICANT:

☐ Trainee Permit (TR)

Please Read Application Guide Prior to Completing this Application.

Name		
Any other Names Used		
Mailing Address		
City	State	Zip Code
County	Home Telephone	Work Telephone
Social Security #		Date of Birth



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EDUCATION

List the names of all institutions attended, the beginning and graduation dates at each institution, and degree(s) awarded (if applicable).

NAME OF SCHOOL	DATES ATTENDED	DATES GRADUATED	DEGREE AWARDED

PLEASE ANSWER THE FOLLOWING:

CRIMINAL HISTORY RECORDS CHECK PROCEDURE

Pursuant to 5 M.R.S.A. §5301-5303, the State of Maine is granted the authority to take into consideration an applicant's criminal history record. The Office of Licensing and Registration requires a criminal history records check as part of the application process for all applicants.

1. Have you ever been or convicted of, or plead guilty to a crime? ☐ Yes ☐ No
If yes, please list date(s) and crime(s), and submit a copy of the court judgment(s).

To Be Completed by the Supervising Dealer:

Affiliated Business		License Number
Mailing Address		
City	State	Zip Code
Licensed Dealer Responsible For Supervision		License Number
Signature of Supervising Dealer		Date

By my signature, I affirm that all information provided in connection with this application is true to the best of my knowledge and belief, with the understanding that any omissions, inaccuracies, or failure to make full disclosure may be deemed sufficient reason to suspend or recommend revocation of a license issued by the Department. I further authorize all law enforcement agencies and officials thereto to release to the Department any and all criminal history record information pertaining to myself.

Signature of Applicant

Date

VERIFICATION OF TRAINEE PRACTICUM FORM

1. Trainee Data --To be Completed in Full by Trainee

Name of Trainee		License Number	
Mailing Address	City	State	Zip Code
Work Telephone		Home Telephone	
Place of Employment during Training Period			

2. To be Completed in Full by Supervising Licensed Dispenser

Supervising Licensed Dispenser Data

Name of Dealer		License Number	
Mailing Address	City	State	Zip Code
Work Telephone		Home Telephone	

Employment Data

Name of Business		License Number	
Mailing Address	City	State	Zip Code
Business Telephone Number			

3. Trainee Practicum Information - Guidelines

A trainee, along with completion of the oral and written examinations, must be supervised by a licensed Hearing Aid Dealer and Fitter for a minimum of 750 hours in the practice of fitting and dealing in hearing aids during a period of not fewer than 6 nor more than 12 months.

The following is a list of suggested guidelines in which the trainee should be proficient in after completing the supervision period:

- | | |
|--|---|
| A. Hearing Aid Selection | L. Masking |
| B. Hearing Aid Modifications | M. Identification of Outer & Inner Ear Anomalies |
| C. Technology of Hearing Aids | N. Earmolds and Shell Modification |
| D. Demonstrates Real Ear Technology | O. Laws Governing the Licensing of Persons for Fitting and Dispensing Hearing Aids in the State of Maine |
| E. Follow-up Visits and Counseling | P. FDA and FTC Regulations |
| F. Assessment and Hearing Aid Evaluations | Q. Sales and Finalization of Contracts |
| G. Speech Testing | R. 30 Day Trial Knowledge |
| H. Taking Case Histories | |
| I. Otoscopic Examinations | |
| J. Earmold Impressions | |
| K. Trouble Shooting Hearing Aids and Earmolds | |

4. To be Completed in Full by Supervising Licensed Dispenser

The Trainee must keep a log, which is signed by the supervising licensed dispenser. You may be required to provide documentation of completion of the 750 supervised hours to satisfy these guidelines.

Dates the Applicant was under your Training: From _____ To _____
month/day/year month/day/year

I hereby certify that the information given above is correct to the best of my knowledge. I further certify that the direct supervision of the trainee was done in accordance with Chapter 1(2)(A) and (B) of Board Rules.

Signature of Supervising Dispenser: _____ Date: _____

Signature of Trainee: _____ Date: _____



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ANNE L. HEAD
DIRECTOR



AUTHORIZATION OF CREDIT CARD PAYMENT

Fees owed to this Department may be paid by the use of a credit card. If you wish to pay your fee(s) with your credit card, please complete this form and send it with your application. Payment through credit cards will not be processed without this authorization form.

Name: (applicant fees being paid for)		
Mailing Address: (applicant fees being paid for)		
City:	State:	Zip Code:
County:		Telephone #: (____) _____ - _____

Name of cardholder: (if other than applicant)		
Mailing Address: (if other than applicant)		
City:	State:	Zip Code:

I authorize the State of Maine, Department of Professional and Financial Regulation, Office of Licensing and Registration to charge my:

☐ Visa ☐ MasterCard _____ **Card number**

Expiration date: ____/____/____ **in the amount of: \$** _____

Signature: _____ **Date:** ____/____/____



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JOHN ELIAS BALDACCI
GOVERNOR

ANNE L. HEAD
DIRECTOR

ACCOMMODATION REQUEST FORM

The information requested below and any documentation regarding your disability and your need for accommodation in testing will be considered strictly confidential and will not be shared with any outside source without your express written permission.

Name: _____
Address: _____
Telephone #: _____ Social Security Number: _____

Accommodations Requested for the _____ Examination.
Disability _____

Please check all that apply

- ☐ **Accessible Testing Site**
- ☐ **Separate Testing Site**
- ☐ **Braille**
- ☐ **Large Print**
- ☐ **Tape**
- ☐ **Reader as Accommodation for Visual Impairment**
- ☐ **Scribe/Amanuensis as Accommodation for Visual or Motor Impairment**
- ☐ **Reader as Accommodation for Learning Disability**
- ☐ **Scribe/Amanuensis as Accommodation for Learning**
- ☐ **Sign Language Interpreter**
- ☐ **Extended Time**
- ☐ **Time-and-a-half**
- ☐ **Double time**
- ☐ **More than double time (specify) _____**
- ☐ **Use of Computer or Other Adaptive Equipment (specify) _____**
- ☐ **Other: _____**

Signed and Dated: _____



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DOCUMENTATION OF DISABILITY RELATED NEEDS

If you have a learning disability, a psychological disability, or other hidden disability that requires an accommodation in testing, please have this section completed by an appropriate professional (education professional, doctor, psychologist, psychiatrist) to certify that your disabling condition requires the requested test accommodation.

If you have existing documentation of having the same or similar accommodation provided to you in another test situation, you may submit such documentation instead of having this portion of the form completed.

I have known _____ since _____ in my capacity as a
(Test applicant) (Date)

(Professional title)

The applicant has discussed with me the nature of the test to be administered. It is my opinion that because of this applicant's disability, he/she should be accommodated by providing the following: (check all types)

- ☐ **Taped test**
- ☐ **Large print test**
- ☐ **Reader**
- ☐ **Scribe/amanuensis**
- ☐ **Extended time**
- ☐ **Time-and-a-half**
- ☐ **Double time**
- ☐ **More that double time (please justify) _____**
- ☐ **Separate Testing Area**
- ☐ **Use of Computer or Other Adaptive Equipment (please specify) _____**
- ☐ **Other (please specify) _____**

Signed: _____ **Title:** _____

Date: _____ **License # (if applicable):** _____



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